

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

01321

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:

County St. Mary's
City or town Leonardtown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Sept
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County St. Mary's
City or town Leonardtown
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2. (a) If veteran, name war.

3. (a) FULL NAME

Salomon Abell

3. (b) Social Security Number

4. Sex m 5. Color or race w 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Henrietta Abell

6. (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) Sept. 29, 1864

8. AGE: Years 82 Months 6 Days _____ it less than one day _____ hrs. _____ min.

9. Birthplace md
(Town, county, and state)

10. Usual occupation none

11. Industry or business

12. Name Salomon Abell

13. Birthplace St. Mary's Co., Md.

14. Maiden name Henrietta S. Jenkins

15. Birthplace Leonardtown, Md.

16. Informant Wm. Abell

Address Leonardtown

17. Burial, cremation, or removal. Which? Burial Date thereof 4/15/47
(month) (day) (year)

Cemetery or crematory St. Mary's

Location Leonardtown

18. Funeral director W.B. Robinson

Address Leonardtown

19. 4/13/47 47 Cavalry
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1947 at 4:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 8 to Apr. 12 1947 and that I last saw him alive on Apr 8 1947

Immediate cause of death _____ DURATION _____

Cerebral Hemorrhage

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Moans of injury _____ Injured at work? _____

Paul A. Cavalieri

23. SIGNATURE _____ M. D. or other _____

Address Leonardtown Date signed 4/13/47

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 15 1947

BUREAU 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1702

CERTIFICATE OF DEATH

01322

MB MV

Reg. Dist. No.

1. PLACE OF DEATH:
County St. Mary's
City or town Park Hall, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Months
Hospital, institution, or street address where death occurred:
Park Hall, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State South Carolina County
City or town Rural Hallsboro
(If outside city or town limits, write RURAL and give nearest town)
Street No. Route 1 Box 109, Hallsboro
(If rural, give LOCATION)
2. (a) If veteran, name war ✓

3. (a) FULL NAME
Anderson, Austin Lee

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
6. (b) Name of husband or wife
7. Birth date of deceased (mo., day, yr.) 12/22/25 6. (c) If alive, give age years
8. AGE: Years 21 Months 4 Days 5 It less than one day hrs. min.

9. Birthplace North Carolina
(Town, county, and state)
10. Usual occupation Aviation Machinest Mate
11. Industry or business U.S. Navy
12. Name J. W. Shipman (God Father)
13. Birthplace Unknown
14. Maiden name Unknown
15. Birthplace

16. Informant U.S. Navy
Address Patuxent River, Md.
17. Removal 4/28/47
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory
Location Whiteville, North Carolina

18. Funeral director P. B. Robinson
Address Leonardtown, Maryland
19. 4/27 47 Cavalier
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 April 1947, at 705A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dead on arrival at US NAS Patuxent
and that I last saw h. alive on River, Maryland

Immediate cause of death Fracture, Compound, Skull
DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.
Autopsy results Fracture, Compound, Skull;
PHYSICIAN: Please underline the cause to which death should be charged Contusions and Lacerations Brain

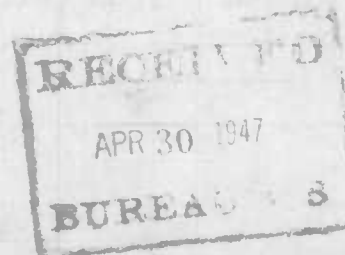
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 4/27/47
Where did injury occur? Park Hall, St. Mary's Maryland
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Park Hall Md.
Means of injury Automobile Accident Injured at work? No

23. SIGNATURE CDR. L.H. Bell (MC) USN
US NAS Patuxent River, Md.
Address Francis T. Kessinger Date signed 4-27-47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 149-E

CERTIFICATE OF DEATH

Reg. Dist. No. 01323

1. PLACE OF DEATH:

County St. Mary's
 City or town Leonardtown Md
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, institution, or street address where death occurred:

St. Mary's Hospital
8 days

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Mary's

City or town Ridge
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Anna F. Szymczyk Barnes

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.) Aug 4 - 1925

8. AGE: Years 21 Months 8 Days 2 If less than one day _____ hrs. _____ min.

9. Birthplace Buffalo New York
 (Town, county, and state)

10. Usual occupation House wife

11. Industry or business _____

12. Name John Szymczyk

13. Birthplace Warsaw Poland

14. Maiden name Juliana Szymczyk

15. Birthplace Warsaw Poland

16. Informant Walter Richard Barnes

Address Ridge Md

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof April 9, 1947
 (month) (day) (year)

Cemetery or crematory St. Michael Cemetery

Location Ridge Md

18. Funeral director W. C. Manning & Sons

Address Leonardtown Md

19. April 8 1947 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1947 at 12:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 17 to April 6 1947

and that I last saw her alive on April 6 1947

Immediate cause of death _____

Pertussis 6 days

Due to Endometritis 6 days

Endometritis 6 days

Due to _____

Other conditions Pregnancy 42 weeks

(Include pregnancy within 8 months of death)

Major findings of operations Pregnancy, Cesarean section Date of op. 3/31/47

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Julian J. Lane MD M. D. or other _____

Address Leonardtown Md Date signed 4/8/47

RECEIVED

APR 10 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-2

CERTIFICATE OF DEATH

Reg. Dist. No. 01324

1. PLACE OF DEATH:

County St Marys
 City or town Leonardtown Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St Marys
 City or town Leonardtown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Mildred L. Brooks

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female colored Widowed

6. (b) Name of husband or wife

7. Birth data of deceased (mo., day, yr.) Aug 24 - 1904

6. (c) If alive, give age _____ years

8. AGE: Years 42 Months 8 Days 1 If less than one day _____ hr. _____ min.9. Birthplace Leonardtown St Marys Maryland
(Town, county, and state)10. Usual occupation House keeper

11. Industry or business

12. Name Philip H. Butler
13. Birthplace St Marys Co14. Maiden name Ada Butler15. Birthplace St Marys Co16. Informant James R. Brooks
Address Leonardtown Md17. (Burial, cremation, or removal. Which?) Burial Date thereof April 28 1947
(month) (day) (year)Cemetery or crematory Our Ladies ChapelLocation near Leonardtown Md18. Funeral director W.C. Armstrong & SonsAddress Leonardtown Md19. 4/27/47 Amulius
(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1947 at 9:45 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from on April 25 to 1947and that I saw the body on _____ 19____
Immediate cause of death Pulmonary HemorrhageDue to (Probable) Intercurrent

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE James F. Greenwell M. D. or other _____Address Leonardtown Md Date signed April 26 1947

RECEIVED

APR 29 1947

BUREAU V B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 70

CERTIFICATE OF DEATH

01325

Reg. Dist. No. 282

1. PLACE OF DEATH:

County St Marys
 City or town Leonardtown Md
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

9 days
 Hospital, institution, or street address where death occurred
St Marys Hospital

How long in hospital or institution?

3. (a) FULL NAME

Peter Bussler
 4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

may 4 - 1893
 8. AGE: Years 53 Months 10 Days 17 (If less than one day) hrs. min.

9. Birthplace

Compton St Marys Md
 (Town, county, and state)

10. Usual occupation

paper carrier

11. Industry or business

John Bussler
 12. Name John Bussler
 13. Birthplace Germany

MOTHER

14. Maiden name Hate Knott
 15. Birthplace St Marys Co

16. Informant J. Frank Bussler
 Address Leonardtown Md R.F.D. #2

17. Burial Date thereof April 7 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Christ Church Cemetery
 Location Chaptice Md

18. Funeral director W C Mattingley Sons
 Address Leonardtown Md

19. 4/7 19 47 Cavalier
 (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St Marys
 City or town Leonardtown R.F.D. #2
 (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH April 5 19 47 at 12:25 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 27 19 47 to April 5 19 47
 and that I last saw him alive on 5-5-47

Immediate cause of death

Pachymeningitis
Chronic Alcoholism

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed April 6 47

RECEIVED
APR 8 1947
BUREAU 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

01326

836

282

1. PLACE OF DEATH:

County St. Mary's
 City or town Caltons Point
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County St. Mary's
 City or town Caltons Point
 (If outside city or town limits, write RURAL and give nearest town)

Street No.
 (If rural give LOCATION)

2. (a) If veteran, name war World War II

3. (a) FULL NAME

Thomas Stanley Cheseldine

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) December 8 1897

8. AGE: Years Months Days It less than one day
49 hrs. min.

9. Birthplace Maryland
(town, county, and state)10. Usual occupation Walterman

11. Industry or business

12. Name Joseph B. Cheseldine13. Birthplace Maryland14. Maiden name Mrs. Mattingly15. Birthplace Maryland16. Informant Joseph B. CheseldineAddress Caltons Point, Md.17. Burial Date thereof 5/5/47
(Burial, cremation, or removal Which?) (month) (day) (year)Cemetery or crematory Winston NationalLocation Winston Virginia18. Funeral director C. B. RobinsonAddress Leonardtown, Md.572 47 Cavalier19. (Date rec'd by registrar) 19 5/1/47 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30, 1947 at 10:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from around the house on May 1st 1947
 and that I last saw him alive on 18 May 1st

Immediate cause of death Coronary Embolism DURATION few mins

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

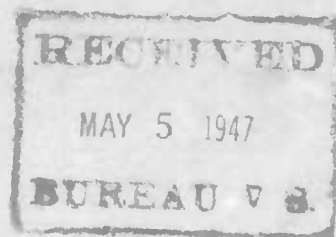
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Francis F. Greenwell

M. D. or other

Address Leonardtown, Md. Date signed 5-1-47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

CERTIFICATE OF DEATH

Reg. Dist. No. 01327

1. PLACE OF DEATH
County St Mary's
City or town Holly Wood Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County St Mary's
City or town Holly Wood
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D. 1
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
Charles King Clarke

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Jan 25 - 1878 5. (c) If alive, give age years

8. AGE: Years 69 Months 2 Days 22 If less than one day hrs. min.

9. Birthplace Holly Wood St Mary's Md
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name C. King Clarke
13. Birthplace St Mary's Co

14. Maiden name Rebecca Greenwell
15. Birthplace St Mary's Co

18. Informant Philip S. Clarke
Address Leonardtown Md

17. Burial Date thereof Apr 28 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St Johns Cemetery
Location Holly Wood Md

18. Funeral director W. C. Mattingly Sons
Address Leonardtown Md

19. 7/17 47 Corcoran
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 - 1947 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 1944 to April 15 1947
that I last saw him alive on April 15 1947

Immediate cause of death Ant. Infarction of heart DURATION 10 min

Due to Chronic Hypertension 4 yrs

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

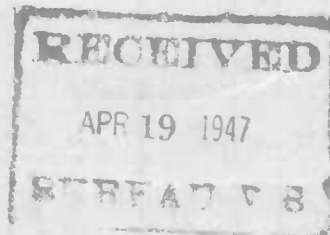
23. SIGNATURE Francis F. Greenwell Md
M. D. or other

Address Leonardtown Md Date signed 4-17-47

MARGIN RESERVED FOR BINDING

VS 415 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9262

01328

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... St. Marys
City or town..... Compton Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 20 years
Hospital, institution, or street address where death occurred:
Compton Maryland
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... St. Marys
City or town..... Compton
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2. (a) If veteran, name war.....

3. (a) FULL NAME

Willis Cook

3. (b) Social Security Number

4. Sex..... Male 5. Color or race..... Colored 6. (a) Single, married, widowed, or divorced..... married
6. (b) Name of husband or wife..... Mary Francis Cook
7. Birth date of deceased (mo., day, yr.)..... Feb - 2 - 1865
6. (c) If alive, give age..... 68 years
8. AGE: Years..... 82 Months..... 2 Days..... 18 If less than one day..... hrs. min.

9. Birthplace..... Philadelphia Pa
(Town, county, and state)
10. Usual occupation..... Boat Building
11. Industry or business.....

FATHER
12. Name..... Willis Cook
13. Birthplace..... unknown
MOTHER
14. Maiden name..... Francis Cook
15. Birthplace..... unknown

16. Informant..... Mary Francis Cook
Address..... Compton Maryland
17. Burial..... Burial Date thereof..... April 21 - 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory..... St. Francis Cemetery
Location..... Compton Md

18. Funeral director..... W. C. Mattingley Sons
Address..... Leonardtown Md
19. 4/20 19 47 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... April - 19 - 1947 at..... 8:53 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... Mar 1946 to..... April 1947
and that I last saw him alive on..... April 18 1947
Immediate cause of death..... Fibrillation of Heart
Due to..... Insufficiency of Aortic Valve
Due to..... Coronary
Other conditions.....
(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur?.....
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury..... Injured at work?

23. SIGNATURE..... J. F. Greenwell M. D. or other
Address..... Leonardtown Md Date signed.....

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 22 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 920

01329

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH:

County... St. Mary's
 City or town... Rural, Scotland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 69 yrs
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... St. Mary's
 City or town... Rural, Scotland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Robert Cullison

3. (b) Social Security Number

4. Sex Male 5. Color or race Black 6.(a) Single, married, widowed, or divorced Married
 8.(b) Name of husband or wife Florence Cullison
 7. Birth date of deceased (mo., day, yr.) March 5 1868 6.(c) If alive, give age 59 years
 8. AGE: Years 71 Months 1 Days 0 If less than one day _____ hrs. _____ min.

9. Birthplace Scotland Md.
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Punch Cullison
 13. Birthplace Maryland
 14. Maiden name Unknown
 15. Birthplace _____

16. Informant Florence Cullison
 Address Scotland, Md.

17. Burial Date thereof April 7, 1947
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory St. Luke's Cemetery
 Location Scotland, Md.

18. Funeral director E. L. Robinson
 Address Dameron, Md.

19. April 5, 1947
 (Date rec'd by registrar) pp Beary, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1947 at 2 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 1947 to April 5, 1947
 and that I last saw him alive on April 3, 1947

Immediate cause of death _____

Valvular heart disease DURATION 5 years

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

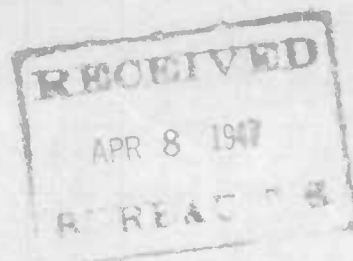
Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE pp Beary, MD M. D. or other

Address Great Mills, Md. Date signed 4-5-47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (70-2)

CERTIFICATE OF DEATH

01330

MV Reg. Dist. No.

1. PLACE OF DEATH:

County St. Mary's
 City or town US NAS Patuxent River Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 Months and 15 days
 Hospital, institution, or street address where death occurred:
Dispensary, US NAS Patuxent River, Md.
 How long in hospital or institution? 10 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
New Jersey
 State New Jersey County Elizabeth, New Jersey
 City or town 15 Smith Street
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 15 Smith Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

Emery, George Edward

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife.....
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) 10/22/27
 8. AGE: Years 19 Months 6 Days 4 If less than one day
 hrs. min.

9. Birthplace Elizabeth, New Jersey
 (Town, county, and state)
Seaman, First Class
 10. Usual occupation
 11. Industry or business U.S. Navy

12. Name Emery, Albert C.
 13. Birthplace Unknown
 14. Maiden name Unknown
 15. Birthplace Unknown

16. Informant U.S. Navy
 Address Patuxent River Md.
Removal
 (Burial, cremation, or removal. Which?) Date thereof 4/27/47
 (month) (day) (year)

Cemetery or crematory.....
 Location Elizabeth, New Jersey
P.B. Robinson
 18. Funeral director
 Address Leonardtwn, Maryland

19. 4/27 47 Cremation
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 April 1947 at 927 P M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased xxx
On 26 April 1947 to
 and that I last saw him in alive on 26 April 1947
 Immediate cause of death Intracranial Injuries

Jeep Accident
 Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
Fracture, compound, skull; Contusions
Antopsy results and lacerations, brain
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Accident Date of 4/26/47
 Where did injury occur? US NAS Patuxent River, Maryland
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) Naval Air Station
 Means of injury Jeep turned over Injured at work? Yes

L.H. Bell
 23. SIGNATURE CDR. L.H. Bell (MC) USN
US NAS Patuxent River, Maryland
 Address Francis F. Howard M.D. Doctor
 Date signed 4/26/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 29 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

CERTIFICATE OF DEATH

01331

Reg. Dist. No. 2-16

1. PLACE OF DEATH:

County St. Mary'sCity or town St. Mary's
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 42 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

George Gibson4. Sex m 5. Color or race w 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife May Indiana Gibson7. Birth date of deceased (mo., day, yr.) 3-25-1864 6. (c) If alive, give age 76 years8. AGE: Years 81 Months 9 Days 21 If less than one day _____ hrs. _____ min.9. Birthplace Catonsville, Md
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name William Gibson13. Birthplace Catonsville, Md14. Maiden name Frances Russell15. Birthplace St. Mary's, Co. Md16. Intermant Geo. Harriet GibsonAddress avenue md17. burial Date thereof _____ (month) (day) (year)

(Burial, cremation, or removal, Which?)

Cemetery or crematory St. Mary'sLocation Baltimore18. Funeral director W. S. Walters, SonAddress Imperial St. and19. 1-18-1947 19. 1947 Registrar W. S. Walters

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County St. Mary'sCity or town St. Mary's
(If outside city or town limits, write RURAL and give nearest town)Street No. md

(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-19-47 19 _____ at 10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4-14-47 19 47 to 4-18-47 19 47and that I last saw him alive on 4-15-47 19 47Immediate cause of death CerebralapoplexyDue to arteriosclerosis

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. S. Walters

M. D. or other _____

Address avenue md Date signed 7-19-47

RECEIVED
APR 22 1947
BUREAU 3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-2)

01332

CERTIFICATE OF DEATH

Reg. Dist. No. 288

1. PLACE OF DEATH:

County St Marys
 City or town Leonardtown Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 1/2 days
 Hospital, institution, or street address where death occurred:
Leonardtown Md
 How long in hospital or institution? St Marys Hospital 1 1/2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St Marys
 City or town Clements
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Rt 2
 (If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Joseph Elmore Guy

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Mary Catharine Guy7. Birth date of deceased (mo., day, yr.) Sept 25 - 1902 6. (c) If alive, give age 43 years8. AGE: Years 44 Months 6 Days 21 If less than one day hrs. min.9. Birthplace Clement St Marys Maryland
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name John E. Guy13. Birthplace St Marys Co14. Maiden name Blanche Weaver15. Birthplace St Marys Co16. Informant Mrs Mary Catharine GuyAddress Clements Md17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof April 17 1947
(month) (day) (year)Cemetery or crematory St Joseph CemeteryLocation Maryland Md18. Funeral director W C Mattingly SonAddress Leonardtown Md19. 4/16 47 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1947, at 3:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 9 1947 to Apr 14 1947and that I last saw him alive on Apr 14 1947Immediate cause of death Cerebral Hemorrhage

DURATION

Due to Styphidulosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Meana of injury Injured at work?

23. SIGNATURE Frank A. Canalis M. D. or other
Address Leonardtown Date signed 4/16/47

RECEIVED

APR 19 1947

BUREAU U S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01333

Reg. Dist. No.

1. PLACE OF DEATH:

County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....
 (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced.....

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

8. AGE: Years..... Months..... Days..... It less than one day..... hrs..... min.

9. Birthplace.....

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial, cremation, or removal (Which?)..... Date thereof.....

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Date rec'd by registrar.....

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 21 1947 to Apr 25 1947

and that I last saw him alive on Apr 24 1947

Immediate cause of death.....

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... M. D. or other

Address..... Date signed.....

RECEIVED

APR 29 1947

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83-2

CERTIFICATE OF DEATH

Reg. Dist. No.

01334

1. PLACE OF DEATH:

County St. Mary'sCity or town Leonardtown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

St. Mary's Hosp.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County St. Mary'sCity or town Ridge
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2. (a) If veteran, name war.

3. (a) FULL NAME

Harriet Kopenell

3. (b) Social Security Number

4. Sex

female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

? 1863

6. (c) If alive, give age years

8. AGE:

84

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

house keeper

11. Industry or business

Unknown

FATHER

12. Name

Unknown

13. Birthplace

MOTHER

14. Maiden name

Hannah Turner

15. Birthplace

Virginia

16. Informant

Betha WilliamsAddress 5915 Mc Mahon Ave. Phila.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

7/29/47
(month) (day) (year)

Cemetery or crematory

St. Luke's

Location

Scotland, Md.

18. Funeral director

P.B. Robinson

Address

Leonardtown Md.

19. (Date rec'd by registrar)

4/27

19. (Date)

47Criminal

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1947, at 7:30 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr 20 1947, to Apr 26 1947and that I last saw him alive on Apr 26 1947Immediate cause of death Coronary Arteriosclerosis

DURATION

Due to

Due to

Other conditions

Due to

Due to

Other conditions

Due to

Due to

Other conditions

Due to

Due to

Other conditions

Due to

Due to

Other conditions

Due to

Due to

Other conditions

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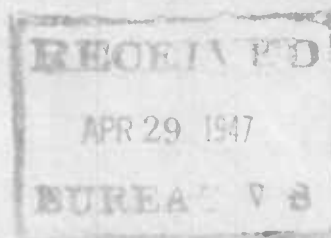
Other conditions

23. SIGNATURE

Frank A. Camilleri

M. D. or other

Address LeonardtownDate signed 4/27/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (118)

CERTIFICATE OF DEATH

01335

Reg. Dist. No. 286

1. PLACE OF DEATH:

County St. Marys
 City or town Coltons Point
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 1/2 yrs.
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Marys
 City or town Coltons Point
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 '2. (a) If veteran, name war _____

3. (a) FULL NAME

Elizabeth Jane Leyde

3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed
 6. (b) Name of husband or wife — Leyde
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) May 30 1860
 8. AGE: Years 86 Months 7 Days 0 If less than one day _____ hrs. _____ min.
 9. Birthplace Pennsylvania
 (Town, county, and state)
 10. Usual occupation none
 11. Industry or business _____

FATHER 12. Name Joseph Baker
 13. Birthplace Pennsylvania
 MOTHER 14. Maiden name Margaret Mc Caslin
 15. Birthplace Pennsylvania

16. Informant Margaret A. Wenderholm
 Address Colton Point, Md.

17. Burial Date thereof 4/ 7/ 47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Graceland
 Location New Castle, Pennsylvania

18. Funeral director Leyde Mortuary
 Address New Castle, Pennsylvania

19. 4-4-47 Th M R Palmer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 19 47 at 6:30pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-2- 19 47 to 4-3- 19 47
 and that I last saw him alive on 4-2- 19 47

Immediate cause of death acute
in digestion DURATION _____

Due to _____
 Due to _____

Other conditions invalid for 1/2
year (Include pregnancy within 3 months of death)

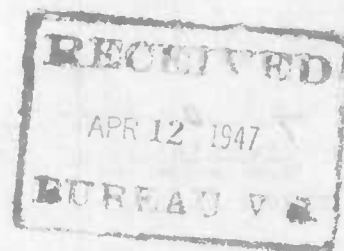
Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Th M R Palmer M. D. or other _____
 Address as above Date signed 4-4-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01336

Reg. Dist. No. 281

1. PLACE OF DEATH:

County St Marys
 City or town Medleys Creek Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St Marys
 City or town Medleys Creek
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Leonardtown Md R. F. D. #7
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Herbert Eugene Norris

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Mary Lucile Norris
 6. (c) If alive, give age 52 years
 7. Birth date of deceased (mo., day, yr.) Aug 12 1889
 8. AGE: Years 57 Months 8 Days 2 If less than one day
 hrs. min.

9. Birthplace near Leonardtown St Marys Maryland
 (Town, county, and state)

10. Usual occupation Farmer11. Industry or business Farmer

12. Name Edward B. Norris
 13. Birthplace St Marys Co, Md.
 14. Maiden name Eloise Th. Norris
 15. Birthplace St Marys Co, Md.

16. Informant Dr. Herbert E. Norris
 Address Leonardtown Md R. F. D. #1

17. Burial Date thereof April 16 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Our Ladies Chapel
 Location near Leonardtown Md

18. Funeral director W. C. Matthews Sons
 Address Leonardtown Md

19. 4-15-1947 R. P. Beary, M.D.
 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1947 at 6:30 A.M.

21. I CERTIFY that death occurred on the data above stated; that I attended deceased from
October 15 1946 to April 14 1947
 and that I last saw him alive on April 13 1947

Immediate cause of death Coronary sclerosis
 DURATION 3 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. P. Beary, M.D.

M. D. or other

Address Great Mills Md Date signed 4-15-47

RECEIVED

APR 17 1947

BUREAU V 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-2

CERTIFICATE OF DEATH

01337

Reg. Dist. No. 282

1. PLACE OF DEATH:

County St. Mary's
 City or town Leonardtown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

St. Mary's Hosp.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Mary's
 City or town St. Mary's City
 (If outside city or town limits, write RURAL and give nearest town)

Street No. —
 (If rural, give LOCATION)

2. (a) If veteran, name war —

3. (a) FULL NAME

William D. Rice

3. (b) Social Security Number

4. Sex

male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Mary M. Rice

7. Birth date of deceased (mo., day, yr.)

July 12, 18956. (c) If alive, give age — years

8. AGE:

Years

Months

Days

If less than one day

57

hrs.

min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

farmer

11. Industry or business

—

FATHER

12. Name

Ely Rice

13. Birthplace

Maryland

MOTHER

14. Maiden name

Upshaw

15. Birthplace

Mary M. Rice

Address

St. Mary's City

17. Burial

(Burial, cremation, or removal. Which?)

Burial

Date thereof

4/13/47

Cemetery or crematory

Mt. Zion

Location

St. Ignace

18. Funeral director

P. B. Robinson

Address

Leonardtown

19.

(Date rec'd by registrar)

19.

47April1947

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 19 47 at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10 19 47 to April 11 19 47
 and that I last saw him alive on April 11 19 47

Immediate cause of death Cerebral HemorrhageDURATION 2 hoursDue to HypertensionDue to Chronic nephritis

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

For H. Patrick M.D.
Leopoldo Pakwa M.D. or other
 Address — Date signed 4-13-47

RECEIVED

APR 15 1947

SURFA

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157c

CERTIFICATE OF DEATH

01338

Reg. Dist. No.

1. PLACE OF DEATH:

County St. Mary's Hospital
 City or town Lemondtown Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 hours
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution? 2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County St. Mary's
 City or town
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Infant Russell -

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced Infant

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) April 13 - 47 6. (c) If alive, give age. years

8. AGE: Years Months Days If less than one day 2 hrs. 10 min.

9. Birthplace Lemondtown Maryland
 (Town, county, and state)

10. Usual occupation Farming

11. Industry or business

12. Name

13. Birthplace

14. Maiden name Mary Virginia Hurry -

15. Birthplace St. Mary's Md.

16. Informant Lucy Anderson

Address Clements Md.

17. Burial Date thereof 4/13/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lemondtown St. Mary's

Location Lemondtown Md.

18. Funeral director Mr. Matthews

Address Lemondtown Md.

19. 4/13 47 Clements
 (Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 19 47

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 hours after birth to April 13 - 47

and that I last saw him alive on April 13 - 47

Immediate cause of death Underdevelopment of fetus

Unable to live after birth -

Due to Malformation of fetus

Due to Anencephalus

[12/47 - alive]

Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Alphus O. Welch MD

Address Chaplin Md. Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 15 1947
BUREAU C B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Ba*

CERTIFICATE OF DEATH

01339

Reg. Dist. No. *281*

1. PLACE OF DEATH:

County *St. Mary's*
City or town *Beachville*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State *Maryland* County *St. Mary's*
City or town *Beachville*
(If outside city or town limits, write RURAL and give nearest town)

Street No. *L*
(If rural, give LOCATION)

2.(a) If veteran, name war *L*

3. (a) FULL NAME

Louis Edward Tennyson

3. (b) Social Security Number

4. Sex *male* 5. Color or race *white* 6. (a) Single, married, widowed, or divorced *widowed*

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) *October 1870*

8. AGE: Years *76* Months Days It less than one day

9. Birthplace *Maryland*
(Town, county, and state)

10. Usual occupation *retired Col. Master*

11. Industry or business

12. Name *Alexander Tennyson*

13. Birthplace *Maryland*

14. Maiden name *Maria Bailey*

15. Birthplace *Maryland*

16. Informant *J. Lloyd Bean*

Address *Beachville, Md.*

17. *Burial* Date thereof *4/16/47*
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *St. Ignatius*

Location *Beachville, Md.*

16. Funeral director *P. B. Delapison*

Address *Leonardtown, Md.*

19. *4-15-* 19 *47* *J. Lloyd Bean, Md.*
(Date rec'd by registrar) Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *April 13* 19 *47* at *1:00 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *April 7* 19 *47* to *April 13* 19 *47*

and that I last saw him alive on *April 12* 19 *47*

Immediate cause of death

Cerebral hemorrhage

Due to

General arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *J. Lloyd Bean, Md.* M. D. or other

Address *Great Mills, Md.* Date signed *4-15-47*

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

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APR 17 1947
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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 74a

CERTIFICATE OF DEATH

Reg. Dist. No. 01340

1. PLACE OF DEATH:

County St. Marys
 City or town Leonardtown Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 days
 Hospital, institution, or street address where death occurred:
St. Marys Hospital Leonardtown Md
 How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Marys
 City or town St. Marys City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

3. (b) Social Security Number

John William Whitam Sr
 4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Jessie Whitam
 6.(c) If alive, give age 56 years
 7. Birth date of deceased (mo., day, yr.) Sept-23-1880

8. AGE: Years 66 Months 5 Days 17 If less than one day _____ hrs. _____ min.

9. Birthplace Cohoes New York
 (Town, county, and state)

10. Usual occupation Fireman

11. Industry or business

12. Name J. W. Whitam
 13. Birthplace England

14. Maiden name Rachelle Humphreys
 15. Birthplace England

16. Informant J. W. Whitam
 Address Leonardtown Md

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof April-11-1947
 (month) (day) (year)
 Cemetery or crematory Chapel Hill Cemetery

Location Lincoln New Jersey

18. Funeral director W. C. Matthews
 Address Leonardtown Maryland

19. 4/10 47 Cammer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April-5-1947 at 11:42 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2 1947 to April 5 1947 and that I last saw him alive on April 5 1947

Immediate cause of death _____

Myocardial Failure

Due to Acute Coronary Occlusion

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert F. Fuchs M.D.
 M. D. or other _____

Address Leonardtown Md. Date signed 4/8/47

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01341

1. PLACE OF DEATH:

County St. Mary's
City or town Leonardtown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
St. Mary's Hosp.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County St. Mary's
City or town Leonardtown
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) if veteran, name war _____

3. (a) FULL NAME

Essie Wilson

3. (b) Social Security Number

4. Sex Female 5. Color or race colored 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) ? 1901 6.(c) If alive, give age _____ years

8. AGE: Years 46 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation housekeeper

11. Industry or business _____

12. Name Clarke Dyson

13. Birthplace Maryland

14. Maiden name Essie Butler

15. Birthplace Maryland

16. Informant Robert Curtis

Address Leonardtown Md.

17. Burial Burial Date thereof 4/21/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Francis Xavier

Location New Town Rock, Annapolis, Md.

18. Funeral director P.B. Robinson

Address Leonardtown

19. 4/27 47 Camalis
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 19 47 at 3:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 25 19 47 to Apr 26 19 47 and that I last saw her alive on Apr 25 19 47

Immediate cause of death _____

Cerebral Hemorrhage

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE Frank A. Camalis

Address Leonardtown Date signed 4/27/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10110

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APR 29 1947
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